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FOR STATE  
HEALTH DEPT

TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. The delay is not to be a reason for not filing it. The delay is not to be a reason for not filing it. The delay is not to be a reason for not filing it.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**2898 MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02880

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CAROLINE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>		c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NORA</b> Middle <b>ANDERSON</b> Last <b>ANDERSON</b>				4. DATE OF DEATH Month <b>MAR.</b> Day <b>9</b> Year <b>1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 6, 1897</b>	9. AGE (In years last birthday) <b>63 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis Anderson</b>				14. MOTHER'S MAIDEN NAME <b>Martha Hopkins</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Wayne Cowby Sr., Denton</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Heart disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) <b>Diabetes Mellitus</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs - 2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
21a. SIGNATURE <b>Dawson &amp; George</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3-11-61</b>	
21b. EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 12, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul</b>		22d. LOCATION (City, town, or country) (State) <b>Near Denton, Md</b>	
23. FUNERAL DIRECTOR <b>Winget Moore &amp; Son Denton</b>				24a. REC'D BY REGISTRAR <b>DATE MAR 15 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2899

CERTIFICATE OF DEATH

02881

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>			c. LENGTH OF STAY IN 1b <u>10 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>North Main Street</u>				d. STREET ADDRESS <u>South Main Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elisabeth</u> Last <u>Bradley</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 14, 1917</u>	
9. AGE (In years lost birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Alexandria, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Timothy Milburn</u>				14. MOTHER'S MAIDEN NAME <u>Betty E. Breeding</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>James E. Bradley, Federalsburg, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420 Coronary Thrombosis</u> DUE TO (b) <u>chronic myocarditis</u> DUE TO (c) <u>Essential Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>5 yrs.</u> <u>5 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 3, 1961</u> to <u>Mar 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>Mar 3, 1961</u> , and that death occurred at <u>9:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank M. Anderson</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-6-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank M. Anderson, M.D.</u>				22d. ADDRESS <u>Federalsburg, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 6, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>C. H. S. King</u>	

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## Reg. Dist. No.

02882

1. PLACE OF DEATH o. COUNTY		CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		MARYLAND		COUNTY		CAROLINE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		RIDGELEY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X		RIDGELEY		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
GERTRUDE						CANNON		MARCH		22		1961			
5. SEX		F		6. COLOR OR RACE		W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		MAY 8, 1878		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife		10b. KIND OF BUSINESS OR INDUSTRY		HOME		11. BIRTHPLACE (State or foreign country)		MARYLAND		12. CITIZEN OF WHAT COUNTRY?		USA	
13. FATHER'S NAME		NOAH TURNER		14. MOTHER'S MAIDEN NAME		CAROLINE TATMAN									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		no		16. SOCIAL SECURITY NO.				17. INFORMANT		Mrs. Jos. Conolly Denton, head		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Dis DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Bronchial Asthma										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I attended the deceased from Mar. 4, 1960, to Mar. 22, 1961, that I last saw the deceased alive on Mar. 22, 1961, and that death occurred at 2:30 P.M. from the causes and on the date stated above.															
ACTUAL SIGNATURE		Charles H. Stonesifer		M.D.		Greensboro, Md.		DATE SIGNED		3-23-61					
PHYSICIAN'S NAME (Type)		Charles H. Stonesifer, M.D.													
22a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		22b. DATE THEREOF		Mar. 24, 1961		22c. NAME OF CEMETERY OR CREMATORY		Denton		22d. LOCATION (City, town, or county)		(State)	
22d. LOCATION (City, town, or county)		Denton, Md.													
23. FUNERAL DIRECTOR'S SIGNATURE		Wm. J. Moore		ADDRESS		Denton, Md.		24a. REC'D BY REGISTRAR		APR 1 1961		24b. REGISTRAR'S SIGNATURE		Arthur L. Thomas	

CERTIFICATE OF DEATH

3000

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is faint and mostly illegible.



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FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please indicate the date of death in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**2901 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02883

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DENTON</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DENTON</b> d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN HARVEY COLLINS</b>				4. DATE OF DEATH Month <b>MAR.</b> Day <b>2</b> Year <b>1961</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN 31, 1885</b>		9. AGE (In years last birthday) <b>76</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WOOD CUTTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>TIMBER</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Collins</b>				14. MOTHER'S MAIDEN NAME <b>Susan Trice</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs J. Harvey Collins</b> Address <b>Denton, MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangled Hernia</b> <b>561.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Exposure</b> (c) <b>Exposure</b> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Rawson O. George</b>				M.D. <b>Rawson O. George M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3-3-61</b>	
EXAMINER'S NAME (Type) <b>Rawson O. George M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Mar 5, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Concord</b>		22d. LOCATION (City, town, or county) <b>Concord MD</b>		(State)	
23. FUNERAL DIRECTOR <b>Wingard</b>				ADDRESS <b>Concord MD</b>		24a. REC'D BY REGISTRAR <b>MAR 9 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

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3303 MONROE ST. ALBANY, N. Y.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2902

## CERTIFICATE OF DEATH

Reg. Dist. No.

02884

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HILLSBORO</b>		c. LENGTH OF STAY IN 1b <b>10 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WALTER MANNING DECKER</b>		4. DATE OF DEATH <b>Mar 16 1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 16, 1877</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Decker</b>		14. MOTHER'S MAIDEN NAME <b>Hansley Purvis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Kenneth Decker</b>		Address <b>Overbrook, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> <b>420.1</b> DUE TO <b>Coronary Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>7 yr</b> (c) <b>7 yr</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General Atherosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 6 1955</b> to <b>Mar 16 1961</b> , that I last saw the deceased alive on <b>March 16 1961</b> , and that death occurred at <b>5 a.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>E. Paul Knotts</b> M.D.		Denton, Md	
PHYSICIAN'S NAME (Type) <b>E. Paul Knotts M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 20, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Upper Ledge</b>	22d. LOCATION (City, town, or county) (State) <b>Upper Ledge, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Edgar Moore</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 20 1961</b>	24b. REGISTRAR'S SIGNATURE <b>Christina L. Knott</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02-28

CERTIFICATE OF BIRTH

1900

NAME OF CHILD		DATE OF BIRTH	
FIRST NAME		LAST NAME	
MIDDLE NAME		SUFFIX	
SEX		AGE	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		DIVORCE	
DEATH		BURIAL	
CITY		COUNTY	
STATE		COUNTRY	
SIGNATURE		DATE	
OFFICIAL		OFFICE	
TITLE		ADDRESS	
CITY		STATE	
COUNTRY		POSTAL CODE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director should detach page 3 and file it with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
TSM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2903

02885

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b>	
c. LENGTH OF STAY IN 1b <b>10 yr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>718 Gay St.</b>		d. STREET ADDRESS <b>718 Gay St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertha Frances Luff</b>		4. DATE OF DEATH Month Day Year <b>March 10 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 19, 1892</b>
9. AGE (In years last birthday) <b>68</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>No Record</b>		14. MOTHER'S MAIDEN NAME <b>No Record</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>John R. Luff, Jr.</b> Address <b>Denton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line, or (b) one cause per line, or (c) one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Coronary thrombosis</b> DUE TO (c) <b>Coronary artery disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive cardio-vasc. disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Several days</b> <b>3 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 10 1961</b> to <b>March 10 1961</b> , that (I) (we) last saw the deceased alive on <b>March 10 1961</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>Kurt Lederer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>KURT LEDERER</b>		22d. ADDRESS <b>Queen Anne Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-13-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>	23d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>E. Bouleis</b>		25a. REC'D BY REGISTRAR <b>March 14 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

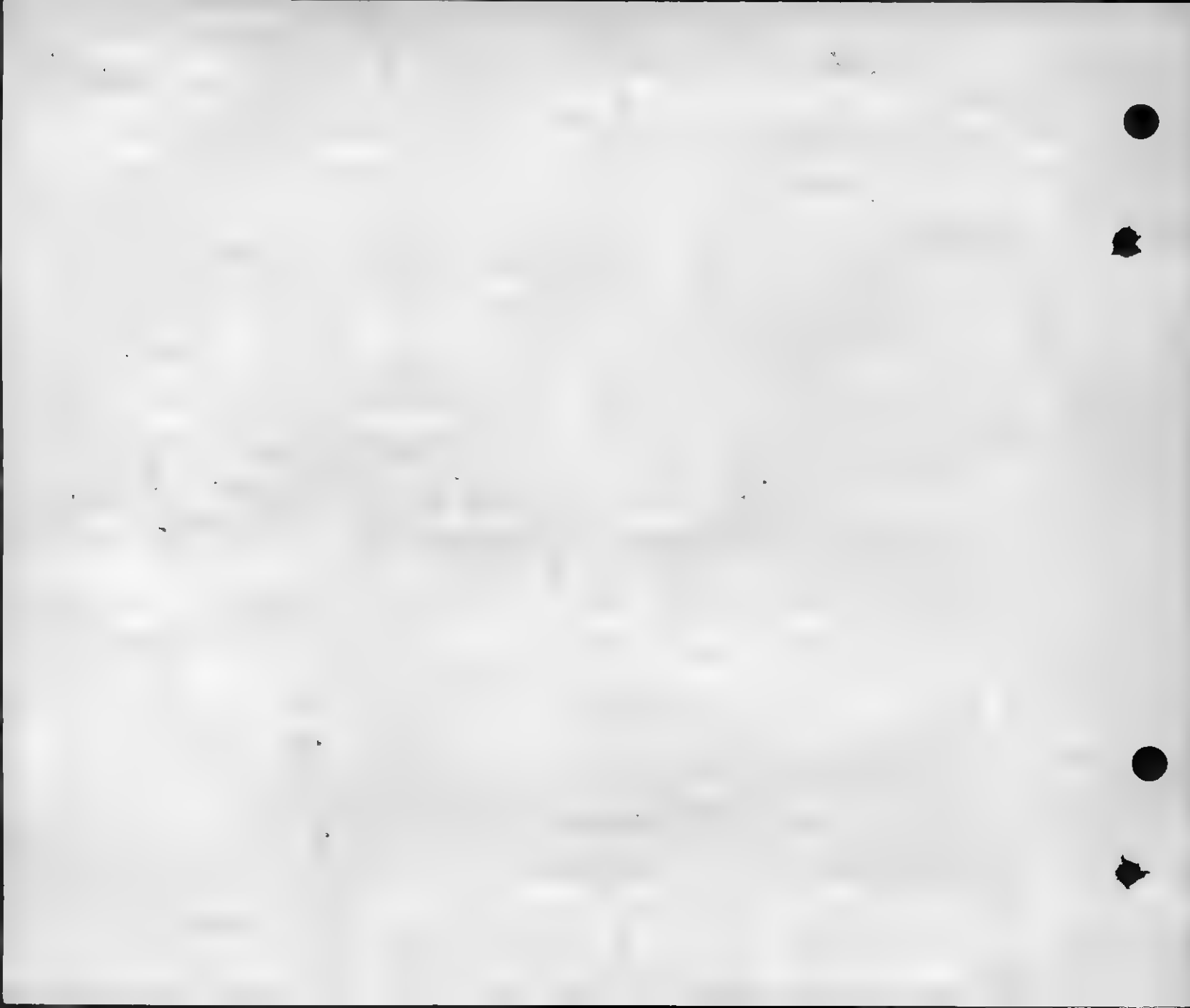
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**2904 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02886

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CAROLINE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RIDGELY</u> c. LENGTH OF STAY IN 1b <u>3 Weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions; Residence before admission) a. <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u> d. STREET ADDRESS <u>20 DISNEY AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>EMMA</u> First <u>CASSANDRA</u> Middle <u>MARTIN</u> Last				<b>4. DATE OF DEATH</b> Month <u>MAR</u> Day <u>3</u> Year <u>1961</u>			
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>JAN 29, 1867</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>HOME</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>HARFORD CO. MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>THOMAS S. DENBOW</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>CATHERINE STRIDEHOFF</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> <u>NO</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> _____ <b>17. INFORMANT</b> <u>Mrs. Wm. Collison, Ridgely Md</u> Address _____			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease Sudden</u> DUE TO (b) <u>Illness of Several Months</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) _____							
<b>20a. EXTERNAL CAUSE WAS</b> PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) _____			
<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Dawson George</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME</b> (Type) <u>Dawson D. George</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>Mar 6, 1961</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Zion</u>	
<b>22d. LOCATION</b> (City, town, or county) <u>Churchville Md</u> (State) _____				<b>23. FUNERAL DIRECTOR</b> <u>John L. Heener</u> ADDRESS _____			
<b>24a. REC'D BY REGISTRAR</b> <u>MAR 7 '61</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Heener</u>			

3-3-61





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2905 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02887**

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg - Rural</b>			c. LENGTH OF STAY IN lb <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg - Rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Concord</b>				d. STREET ADDRESS <b>Near Concord</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Nathaniel</b> Last <b>(Nattie) Melvin</b>				4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>October 8, 1890</b>		9. AGE (In years last birthday) <b>70</b> yrs.	10. IF UNDER 1 YEAR Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	10. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Canning Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Franklin Melvin</b>				14. MOTHER'S MAIDEN NAME <b>Julia FitzHerbert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>222-03-9046</b>		17. INFORMANT Address <b>Mrs. Geneva M. Holland, New Castle, Delaware</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Cardiovascular - Renal disease</b> DUE TO (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dawson O. George</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8-12-61</b>	
EXAMINER'S NAME (Type) <b>Dawson O. George, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 14, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Concord Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Federalsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 14 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the medical examiner. If the word "pending" is in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for 30 days. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1  
FOR STATE  
HEALTH DEPT  
M  
X  
I  
TO DEPT. OF HEALTH  
VS. A15ME  
SM 7/59

2906  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
02888

1. PLACE OF DEATH  
a. COUNTY CAROLINE  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely  
c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ridgely Church

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE MARYLAND  
b. COUNTY Queen Anne  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Queenstown  
d. STREET ADDRESS 17-X2

3. NAME OF DECEASED (Type or print)  
First Middle Last  
Lillie Louise Miller

4. DATE OF DEATH  
Month Day Year  
3 12 1961

5. SEX Female

6. COLOR OR RACE Col

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH  
Month Day Year  
March 13, 1888 71

9. AGE (In years last birthday)  
Months Days Hours Min.  
71

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Housewife

10b. KIND OF BUSINESS OR INDUSTRY  
Domestic

11. BIRTHPLACE (State or foreign country)  
MARYLAND

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME  
JAMES Dobson

14. MOTHER'S MAIDEN NAME  
EMMALINE Dobson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  
—

16. SOCIAL SECURITY NO.  
—

17. INFORMANT  
Address  
Mr. Girard Queenstown, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Myocarditis Acute  
422.2 DUE TO  
Conditions, if any, which gave rise to immediate cause (b) Myocarditis Chronic  
(c) —  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  
—

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. p.m.  
19

20d. INJURY OCCURRED While ☐ Not While ☐  
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Dawson D. George M.D.  
EXAMINER'S NAME (Type) Dawson D. George  
DATE SIGNED 3-14-61

22a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

22b. DATE THEREOF  
3-18-61

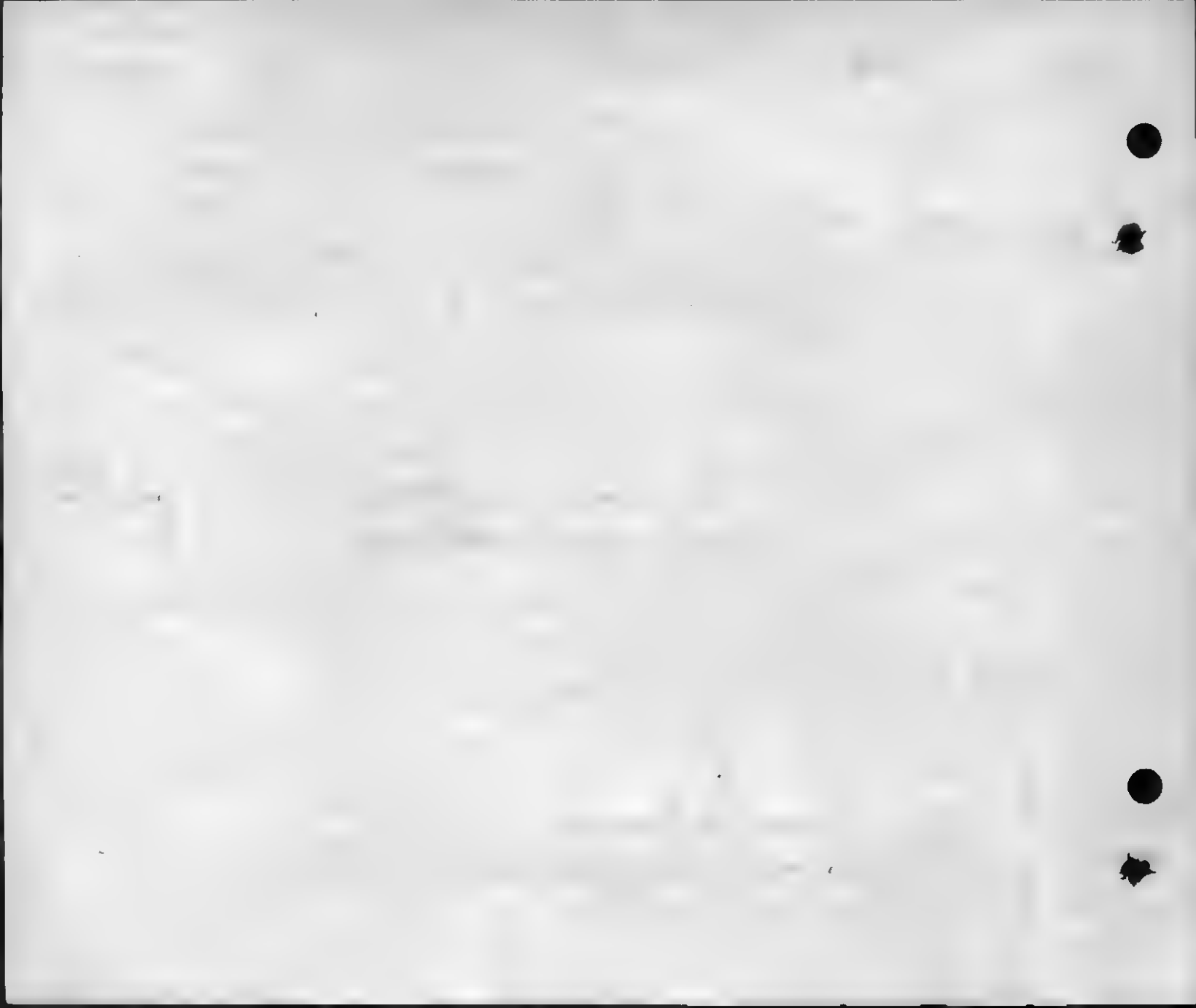
22c. NAME OF CEMETERY OR CREMATORY  
CARMichael Cem

22d. LOCATION (City, town, or country) (State)  
Queenstown Md.

23. FUNERAL DIRECTOR  
Address  
James B. Schell, Easton, Md.

24a. REC'D BY REGISTRAR  
DATE  
MAR 21 '61

24b. REGISTRAR'S SIGNATURE  
Arthur S. Evans





Item 9 & 8 File 6-55 3/23/61 jvk  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

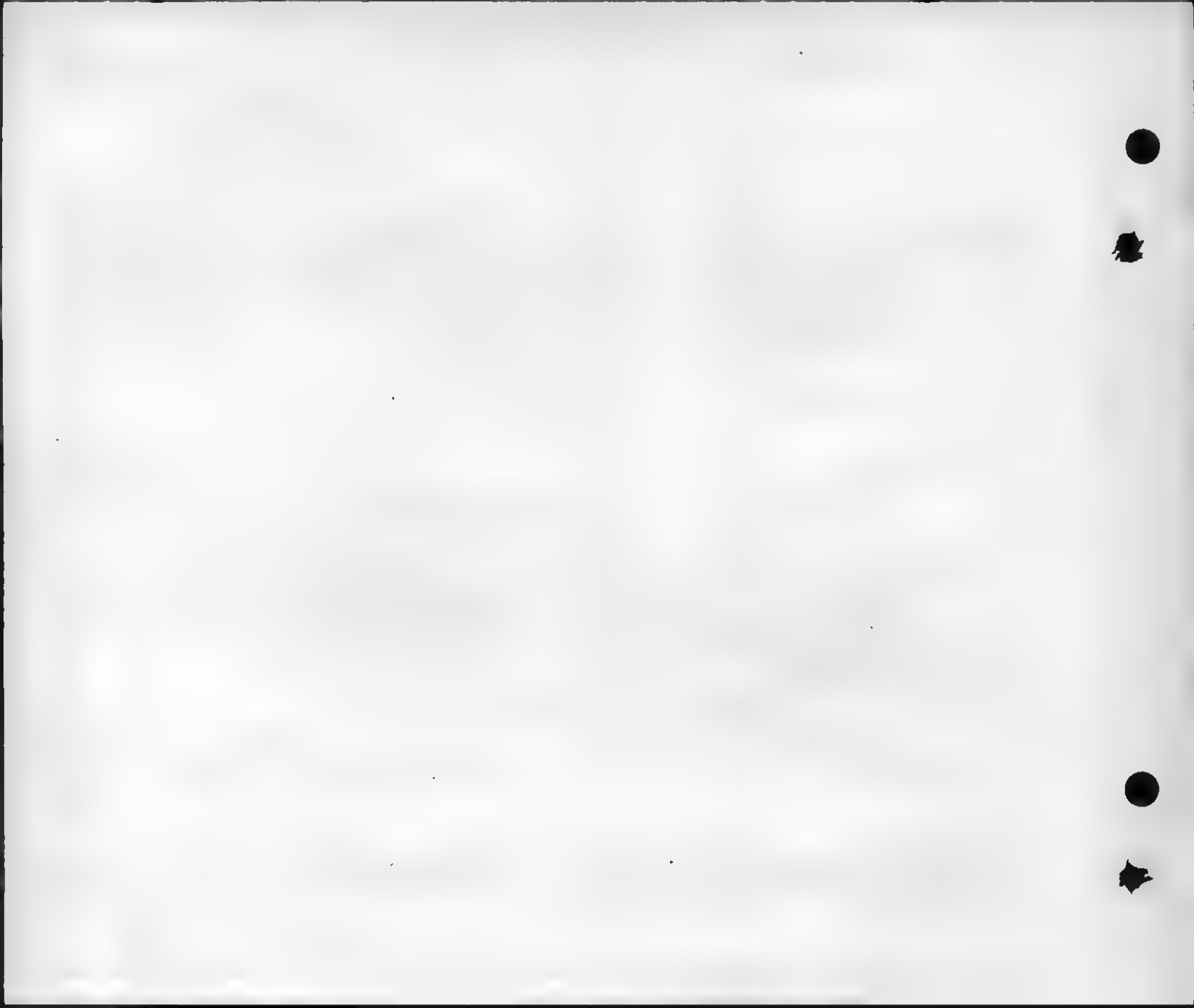
Reg. Dist. No. **12889**

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LACY</b> Middle <b>CAIN</b> Last <b>MURPHY</b>		4. DATE OF DEATH Month <b>MAR</b> Day <b>12</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9, 1889</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STOCK DEALER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CATTLE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Murphy</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Lewis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>0 Mrs. Lacy Murphy Denton, Ind.</b>	
17. INFORMANT <b>S</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Atherosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>general atherosclerosis</b>		4 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 25</b> , 19 <b>59</b> , to <b>March 12</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>March 10</b> , 19 <b>61</b> , and that death occurred at <b>10:15 A</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>E. Paul Knotts</b> M.D.			
PHYSICIAN'S NAME (Type) <b>E. Paul Knotts M.D.</b>		<b>Denton, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 15, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Concord</b>		22d. LOCATION (City, town, or county) (State) <b>Denton, Ind</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Nigel Moore &amp; Son</b> ADDRESS <b>Denton</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 20 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

(M)

(I)

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2908 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02890

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Goldsboro</b>		c. LENGTH OF STAY IN 1b <b>25 yr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Goldsboro</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>				d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Percy</b> Middle <b></b> Last <b>Peirce</b>				4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 15, 1880</b>		9. AGE (In years last birthday) <b>80 yrs.</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FRM Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Peirce</b>				14. MOTHER'S MAIDEN NAME <b>No Record</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mattie Bordley Goldsboro, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis Hemorrhage</b> DUE TO <b>Heart + Kidney Complications</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs 6 mos -</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dawson O. George</b>		EXAMINER'S NAME (Type) <b>Dawson O. George</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3-15-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-17-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Roseville</b>		22d. LOCATION (City, town, or county) (State) <b>Ingleside Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulard</b>				ADDRESS <b>Greensboro, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 16 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the files of the Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files of the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2909

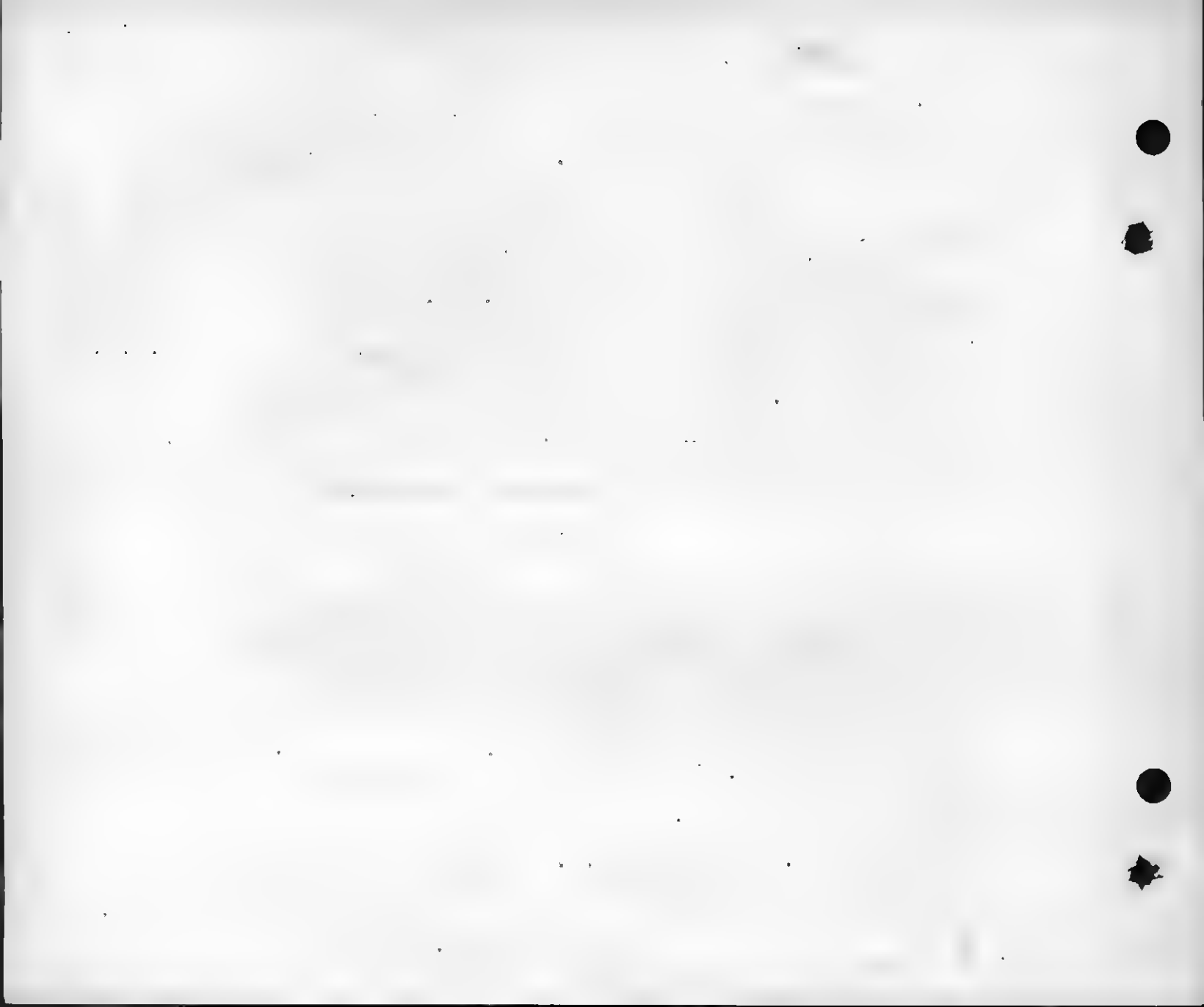
## CERTIFICATE OF DEATH

02891

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Ridgely</b>		c. LENGTH OF STAY IN 1b <b>50 yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Ridgely</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Zoe</b> Middle <b>Powell</b> Last <b>Powell</b>				4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 10, 1889</b>		9. AGE (In years last birthday) <b>71</b> yrs	IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min.	IF UNDER 24 HRS Hours <b>71</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles H. Powell</b>				14. MOTHER'S MAIDEN NAME <b>No Record</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-22-8767</b>		17. INFORMANT <b>Anna Davenport</b>		Address <b>Ridgely, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>SIX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced Generalized</b> DUE TO <b>Arteriosclerosis</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 10, 1961</b> to <b>Mar. 3, 1961</b> that (I) (we) last saw the deceased alive on <b>Mar. 3, 1961</b> , and that death occurred <b>11:30 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles H. Stone</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Stone, Jr., M.D.</b>				22d. ADDRESS <b>Greensboro, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-6-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chapel</b>		23d. LOCATION (City, town, or county) (State) <b>Rural Cardova Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulsie's</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2910

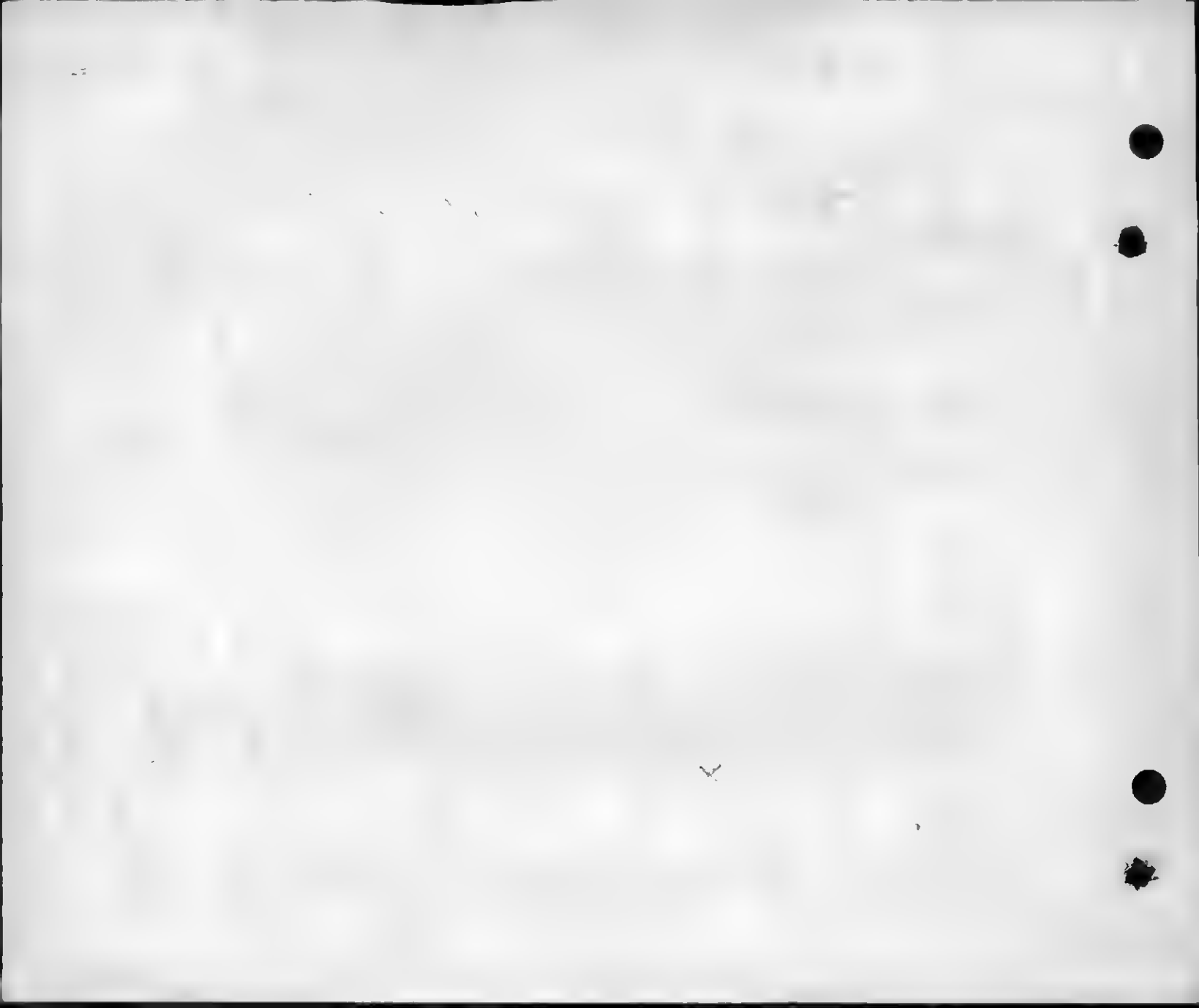
Item 1b Film G282 3/17/61 mh

Reg. Dist. No. 02892

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frederick J. Schlegel</u>		4. DATE OF DEATH <u>March 10 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 3 1897</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Feed mill</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Schlegel</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Cohen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Fred Schlegel</u>		Address <u>Denton</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Danson &amp; George</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DANSON &amp; GEORGE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 12 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenland Cemetery, Md</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Kinn</u>		24. REGISTRAR'S SIGNATURE <u>Charles L. Kinn</u>	
25. REC'D BY REGISTRAR DATE <u>MAR 12 1961</u>		26. REGISTRAR'S SIGNATURE <u>Charles L. Kinn</u>	

MAR 15 '61

Charles L. Kinn



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2911

02893

1 PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Greensboro</b>				c. LENGTH OF STAY IN 1b <b>23 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Greensboro</b>			
f. STREET ADDRESS <b>None</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jesse</b> Middle <b>C.</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>3</b> Day <b>18</b> Year <b>1961</b>			
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-5-1891</b>	
9 AGE (In years last birthday) <b>69</b> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Rep. Pet Milk Co. Retired</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Missouri</b>		11 BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Rep. Pet Milk Co. Retired</b>				12b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13 FATHER'S NAME <b>John Smith</b>				14. MOTHER'S MAIDEN NAME <b>Dora Null</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW 1 509-09-8185</b>		17. INFORMANT <b>Mrs. Mabel Smith Greensboro, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Peptic Ulcer</b>				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) <b>Greensboro, Maryland</b>				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 4, 1961</b> , to <b>Mar. 18, 1961</b> , that (I) (we) last saw the deceased alive on <b>Mar. 17, 1961</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Charles H. Stonesifer</b> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>				22d. ADDRESS <b>Greensboro, Maryland</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-21-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>		23d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Houshais, Greensboro, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Houshais</b>	







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Page 4  
TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

2913

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02895

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridgley</b>		c. LENGTH OF STAY IN 1b <b>2 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>at home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridgley</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Louise</b> Last <b>Wilson</b>		4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1909</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months <b>51</b> Days <b>51</b> Hours <b>51</b> Min. <b>51</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Howard Gardner</b>		14. MOTHER'S MAIDEN NAME <b>Lenora Stallings</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Norman Wilson, Ridgley, Maryland</b>		Address <b>Mr. Norman Wilson, Ridgley, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>433.1</b> DUE TO <b>(Cardiac Arrest.)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Paroxysmal Cardiac Arrhythmia</b> DUE TO (c) <b>Stroke, unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Stroke, unknown</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1961</b> to <b>May 5, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 4, 1961</b> , and that death occurred at <b>10:54</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles H. Winnacott</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Chas H. Winnacott</b>		22d. ADDRESS <b>Ridgley, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/7/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Hampton Gault</b>		25a. REC'D BY REGISTRAR <b>MAR 8 '61</b>	
ADDRESS <b>Easton, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

